.S. No. 300
ev. 10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34660

OCT 20 1952

BIRTH NO. 30942 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 940

1. PLACE OF DEATH
a. COUNTY: GREENE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield
c. LENGTH OF STAY (in this place): 12 Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Burge Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Polk.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Halfway.
d. STREET ADDRESS (If rural, give location): Rt. 2.

3. NAME OF DECEASED (Type or Print): a. (First) Linda b. (Middle) Marie c. (Last) Breshears.

4. DATE OF DEATH: (Month) Oct. (Day) 17 (Year) 52

5. SEX: F. 1
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: Apr 2 - 1952.
9. AGE (In years last birthday): — — IF UNDER 1 YEAR: Months 6 Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — — —
10b. KIND OF BUSINESS OR INDUSTRY: — — — —
11. BIRTHPLACE (City and State or Foreign Country): Mo. U
12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME: Nevin Breshears.
13b. MOTHER'S MAIDEN NAME: Betty Hane.
14. NAME OF HUSBAND OR WIFE: — — —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): — — —
16. SOCIAL SECURITY NO.: — — — —
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Nevin Breshears, Halfway, Mo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumococcal Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 3 4 e 1
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-17, 1952, *to* 10-17-, 1952, *that I last saw the deceased alive on* 10-17-52, 19—, *and that death occurred at* 11:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Paul J. Burch M.D.
23b. ADDRESS: Springfield, Mo
23c. DATE SIGNED: 10-18-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 10-18-52
24c. NAME OF CEMETERY OR CREMATORY: —
24d. LOCATION (City, town, or county) (State): Halfway Mo.

DATE REC'D BY LOCAL REG.: 10-18-52
REGISTRAR'S SIGNATURE: Edith Williamson Deputy Registrar
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Forman Schaupf — Springfield Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by_____, Student Embalmer No. _____, working under my personal supervision.

Student .....
Student Embalmer

Signed L Baker-Gorman

Licensed Embalmer No. 2677

P. O. Address Springfield Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.